



# Confidential Questionnaire

## Chest, Heart & Lung

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Today's Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number Home \_\_\_\_\_ Cellular \_\_\_\_\_ Work \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Imaging Date \_\_\_\_\_

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

### What are your concerns?

Yes No

Have you been diagnosed with:

Heart disease? \_\_\_\_\_

Lung disease? \_\_\_\_\_

Upper spine disorders? \_\_\_\_\_

Do you suffer with upper back pain? \_\_\_\_\_

Do you suffer with chest pain? \_\_\_\_\_

Have you ever had surgery to:

Heart? \_\_\_\_\_

Lungs? \_\_\_\_\_

Mid to upper back? \_\_\_\_\_

Do you have asthma or shortness of breath? \_\_\_\_\_

Do you currently smoke? \_\_\_\_\_

Have you smoked in the past 5 years? \_\_\_\_\_

**Procedure:** You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings. Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose breast disease. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. It does not replace any other breast examination.

**Patient Disclosure:** I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other condition, but will be an analysis of the images with respect only to the thermographic findings discussed in the report.

*By signing below, I certify that I have read and understand the statement above and consent to the examination*

Patient signature \_\_\_\_\_ Today's date \_\_\_\_\_